Theories are lenses through which we investigate the social world.
(de Maio 2010: 28)
Chapter 1  Studying the social aspects of health

Introduction
The main aim of this chapter is to provide you with the understandings you require before embarking on your study of the social aspects of health. These understandings will also help you to apply your knowledge of this subject area in any professional roles you undertake. Comprehensive outlines of relevant academic disciplines and theoretical perspectives are provided. These can be used for reference purposes when reading specific chapters in the book and during any future study of the social aspects of health you may undertake. To further assist you with your current and future explorations of the social aspects of health, towards the end of the chapter there is an explanation about how health data are used and a summary of the established influences on health.

Academic underpinnings
Although several disciplines inform the study of the social aspects of health, it is the sociology of health and illness and the sociology of the body which are most frequently drawn upon. As the discipline of sociology underpins the sociology of health and illness, this section starts with an overview of this subject. The nature and scope of both the sociology of health and illness and the sociology of the body will then be explored, together with their contributions to knowledge about the social aspects of health.

Sociology

Activity 1.1
Which do you think is the most accurate description of sociology?

- Social work
- The study of individuals
- The study of society
- The study of the human social world
- The study of individuals and society

Sociology is the systematic study of the human social world or human society, in that it studies human beings in the social world. Although it sees individuals as highly significant, sociology is different from psychology in that it rejects any explanation which just focuses on ‘individuals’, or argues that individuals are autonomous, and challenges the assumption that social behaviour can be reduced to the study of the individual alone. While sociology looks at both individuals and society, it does more than this in that it looks at individuals operating in the social world and their relationship with that world. It maintains there is a two-way relationship between the individual and society, in that individuals are influenced by society and in turn can influence their social environment. This is represented diagrammatically in Figure 1.1.
Chapter 1  Studying the social aspects of health

The development of sociology is relatively recent as it originated in the early nineteenth century during industrialization. The rapid industrial change that occurred at this time led to questions being asked about the sources of social change, social order, the relationship between the individual and society, and how the society into which people are born shapes their behaviour as individuals (Earle and Letherby 2008; Naidoo and Wills 2008). Sociology augments and supplements knowledge through a range of perspectives in three ways.

■ By giving us new understandings of society. Sociology tries to understand how the social world ‘works’ – what’s going on in society and the changes in society. It also investigates how the two-way relationship between social structures and individuals shapes the actions of each over time. In order to do this, sociology unravels and interprets the structure of society as well as the actions of individuals in a unique way. Consequently, it helps us to see what is going on in society in a new light. The well-known sociologist C. Wright Mills captured this perfectly when he said that ‘doing’ sociology requires thinking in a particular way. He describes this as thinking beyond our own essentially limited experiences and observations of the human social world, and challenging what appear to be the accepted explanations of social phenomena. The ability to adopt such a critical and questioning approach involves what C. Wright Mills describes as a sociological imagination which is seeing ‘personal troubles [as] public issues of social structure’ (Mills 1959: 8).

■ By providing us with evidence and explanations of an extensive range of facets of our human social world. For instance, how society works in terms of what the different institutions do and how they function together. Sociology can also explain the actions of individuals and groups, and patterns of similarity and difference between people within a single society and between societies. Furthermore, it helps us to understand the distribution of social, political and economic resources and power within society. Consequently, sociology can account for why some groups are more powerful than others.

■ By offering explanations that are distinctive from other subjects. Sociological explanations always look beyond the individual to take into account the wider social causes of individual behaviour. For example, when explaining why someone is unemployed, psychological explanations would perhaps look at personality traits such as lack of self-esteem, motivation or particular abilities. A sociological explanation would look at a number of crucial factors that are ‘beyond’ the individual and out there in society and how they affect individuals. As there is a social class gradient in unemployment, with those from the lower social classes experiencing much higher rates of unemployment than those in the higher social classes, one such factor would be social class. A sociological account would also consider the way that some occupational groups are more able to protect themselves from unemployment: higher occupational
groups have more contacts and family ties in business which means they can use these to keep and find employment. In contrast, those in lower occupational groups are often less skilled and less well trained and are consequently more vulnerable to unemployment. Therefore, sociology does not only consider personal characteristics but all those factors in society that could affect an individual’s lack of employment.

The sociology of health and illness
Early sociologists did not discuss health and illness directly. It was not until the 1950s that the value of sociological analysis in this field achieved recognition and even then it did not become established as a sub-discipline until the 1960s and 1970s (Earle and Letherby 2008). Initially it focused on criticizing traditional medical views as being value-laden and highlighted the social control exerted by health professionals through the practice of medicine. During the 1980s, those working within the sociology of health and illness extended its boundaries further and added its voice to the questions that were being raised about the biomedical model’s physiological focus. In doing so, because of its sociological underpinnings, the sociology of health and illness emphasized both the roles of different aspects of our social world beyond the individual and the role of the individual in determining health. The former include social categories, social conditions and social processes. The latter include patients’ own perceptions and knowledge of health.

The sociology of health and illness has now achieved professional and academic recognition. As a result of its further development and sociological underpinnings, it is concerned with all aspects of contemporary life that impinge on well-being throughout the life course. Examples of the wide range of issues that the sociology of health and illness currently addresses are:

- patterns of health and illness in relation to the wider social structure;
- lay perceptions of health and illness;
- the experience of health and illness;
- how certain conditions come to be viewed as illnesses or diseases;
- globalization and health;
- the social organization of formal and informal healthcare;
- the analysis of medical knowledge and professional power;
- lay-professional interactions in healthcare;
- the social and cultural aspects of the body.

In exploring these issues, the sociology of health and illness adopts an eclectic approach in that it embraces other disciplines, such as epidemiology, public health, social policy and psychology. It also employs many well-established sociological perspectives in its explanations.

While the diversity of the content of the sociology of health and illness has been criticized, it has significantly expanded awareness and knowledge of the breadth of social influences on health as
Studying the social aspects of health

well as its social context. In addition, it provides a recognized and dynamic academic base from which to explore, interpret and analyse many social aspects of health.

The sociology of the body

By challenging conventional assumptions about the body and disease, and studying people’s own knowledge of their bodies and perceptions of their bodily experiences, the sociology of health and illness has generated a plethora of studies concerned with the body from a sociological viewpoint. These have been carried out not only within the sociology of health and illness but also in other areas, such as ageing and disability studies. Furthermore, many social changes have increased sociological interest in the body as a social product. For example, the cult of the body in consumer culture means that much modern consumption, such as in the areas of beauty, fashion and leisure, now focuses on goods for body maintenance. Hence the body has become a carrier of commodities which signify particular lifestyles, and create both identity and social status. Medical advances in transplants and cosmetic surgery mean that the concept of a ‘natural body’ is no longer tenable and are further indications of how the body is socially shaped. Demographic changes also mean that there is now a much higher proportion of older people in western societies (see Chapter 5), which has drawn more attention to the physical changes arising from the ageing process and the consequences of living with an ageing body (Shilling 2003; Twigg 2006).

As a result, over the past two decades, much sociological attention has turned to the previously neglected study of the body as both a natural phenomenon and a product of factors ‘beyond’ the individual within the social environment. The body now forms an important dimension of the sociological debate. This in turn has led to the development of the sub-discipline of the sociology of the body, which uses sociological perspectives to provide theoretical insights into key social aspects of the body (Williams 2003; Twigg 2006). These include:

- the impact of environmental, social, political and cultural influences on the body;
- the way the body is shaped by dominant discourses;
- lived experiences of health and illness.

The sociology of the body therefore adds academic rigour to the analysis of many issues about the social aspects of health addressed in this book, and will be used to add depth and understanding to the explorations of chronic illness and disability in particular.

Theoretical underpinnings

The discussion of academic disciplines in the first section makes reference to different theoretical perspectives. When social scientists talk about a theory they mean the set of ideas used to explain aspects of the social world in a systematic and consistent way. These explanations are also supported by evidence and extrapolate from this to develop understandings of social phenomena and predict future occurrences. The set of ideas within each theory are referred to as concepts (see Figure 1.2) which can be single words or a phrase.

The world view of the proponent(s) of a theory influences their interpretation of the evidence, the nature of their explanation and the concepts they develop. The variation in viewpoints is reflected in the differing theoretical perspectives about our social world. In addition, the sets of
Chapter 1  Studying the social aspects of health

Figure 1.2 Theoretical approaches

<table>
<thead>
<tr>
<th>Theory</th>
<th>Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Concepts within each theory are distinctive. For instance, a key concept within Marxist theory is ‘capitalism’ whereas feminist theory uses the phrase ‘inequalities between the sexes’ as one of its main concepts. As many of these theoretical perspectives have both informed, and continue to inform, the study of the social aspects of health, it is therefore essential that the reader is familiar with the main theoretical perspectives. Outlines of the theoretical perspectives that will be used in this book, together with an indication as to which areas of the social aspects of health they will be applied, are set out below.

**Marxist theory**

The emphasis in this theory is on the larger, structural elements of society such as the social, economic, legal and political systems. These are known as the macro elements of social structure. However, Marxist theory places most emphasis on the economic structure, as it maintains that the way the economy of a society is run determines the social relationships in that society. More specifically, it argues that the organization of the ownership of the predominant means of production within an economy leads to specific patterns of class relationships which inevitably entail power differentials and lead to social inequalities. For example, when feudalism was the dominant means of production, there were lords and serfs whose relationships were based on unequal rights and obligations, some of which were established in law. According to Marxist theory, such social relationships only change when the economic relationships change within a society.

Although Marx himself wrote about different historical epochs he concentrated on modern, western economies. He said that these are based on capitalism; within capitalist societies the means of production is profit-making and produces goods for sale using waged labour. There are those who privately own the means of production and those who have to sell their labour power to make a living. The former are called the bourgeoisie. They are the minority and their livelihood is based on the ownership of capital (hence they are also referred to as capitalists), and on producing and trading in commodities by employing waged or salaried labour. Those who have to sell their labour for wages are called the proletariat. They form the majority of the population in capitalist societies and they neither own capital nor do they have any choice about being workers. The bourgeoisie and the proletariat are the two main classes in capitalist societies. The relationship between them is unequal as the bourgeoisie exploit the proletariat in the pursuit of profit. This is described in the following extract from Marx’s work about how capitalists make a profit from the labour of their workers.

> In a certain period of time the worker will have performed as much labour as was presented by his weekly wages. Supposing that the weekly wage of a worker represents three workdays, then if the worker begins on Monday, he has by Wednesday evening replaced to the capitalist the full value of
Chapter 1  Studying the social aspects of health

the wage paid. But does he then stop working? Not at all. The capitalist has bought his weeks’ labour and the worker must go on working also during the last three week days. This surplus labour of the worker, over and above the time necessary to replace his wages, is the source of surplus value, of profit, of the [capitalist’s] steadily growing increase in capital.

(Marx 1867: 58)

Hence, capitalism produces social divisions based on the ownership and non-ownership of the means of production. According to Marx, another consequence of the exploitation of the proletariat by the bourgeoisie was that the former would experience increasing alienation. He predicted that this would lead to social conflict which would result in the eventual overthrow of capitalism and the emergence of socialism (Marx 1867; Giddens 2009).

Marxist theory has been criticized on several counts. One is that it overemphasizes the economic determinants of social relationships and hence class is given primacy in any social analysis using this approach. In addition, Marx’s predictions about such social changes have not been realized and Marxist social analysis has lost some of its pertinence and popularity. Nonetheless, aspects of this theory are frequently referred to in explanations of health and illness. For instance, the sort of inequalities that arise within capitalism, as identified by Marx, have been used to help explain class inequalities in health. Therefore Marxist theory will be returned to in Chapter 3. As it addresses inequalities in power, it is also useful in analyses of experiences of health and illness and the medical profession, and will inform discussions in Sections 2 and 3 of this book.

The emphasis in Marxist theory on the structure of society and the way that it constrains and shapes people means that it provides what is referred to as a structuralist view of society. Structural sociologists, conforming to structuralism, focus on how people’s social behaviour, values and attitudes are largely determined by the organization and structure of the society in which they live, and more particularly, the social groups to which they belong in their society.

As there is coercion by one class and subordination of another within capitalist society, Marxist theory maintains that there is a fundamental conflict between the two classes. It has therefore been argued that it also offers a conflict theory of society. Conflict theorists argue that conflict is inherent in society and question the possibility of ever achieving social stability and equilibrium. This is because they see the unequal distribution of power and resources between groups in society as inevitably leading to some groups being more dominant than others. As a result, interests clash and there is conflict between dominant and subordinate social groups. The assumption in conflict theory that social order can only be maintained by the dominant social groups coercing the subordinate groups strengthens its assertion that consensus cannot exist in society, particularly as this coercion may involve physical force. However, the operation of informal and formal mechanisms of social control engineered by the dominant social groups is more likely to be used for such purposes in western societies (Dahrendorf 1959; Giddens 1984; Steel and Kidd 2001).

Another conflict theory is feminism. This argues that gender conflict is intrinsic to social life and it is to this sociological theory that we now turn.

Feminism
Feminism is a body of thought and a social movement which sees the equality of the sexes as essential and therefore argues for this equality in all areas of life. It explains the inequalities that exist between the sexes, and links this to the way that women have been historically oppressed and excluded from economic power and politics, and have had restrictions placed on them by society.
Chapter 1  **Studying the social aspects of health**

The impossibility of developing ‘a holistic feminist account that speaks for all women’ (Ramazanoglu and Holland 2002: 5) has been a constant theme within feminism. Although there are indeed striking differences between feminists in their values and perspectives (as discussed below), a central theme running through them is that it is men who have oppressed and excluded women because our social system is based on **patriarchy**. As a result, it is assumed that men can and should dominate and have most of the power because they are superior and that women should be subordinate to them. Feminists argue that patriarchy and the power it gives to men results in men being in control of the key institutions that shape our society, such as the judiciary. Our patriarchal social system is also embedded in and reinforced by social institutions. Commonly cited examples of these are the family and the education system. With regards to the former, feminists point to the way that girls, unlike boys, are socialized within the family into thinking that their primary responsibilities are to the home and family. They blame the education system for the gender stereotyping in the careers that girls and boys are trained for and encouraged to pursue (Barker 1997).

Therefore, the main thrust of feminist argument is that the inequalities between men and women are due to the way that patriarchy works in our society, as this means that female inequality and subordination to men is seen as ‘natural’. The most well-known feminist theories are Marxist, radical and liberal feminism. These are discussed in Box 1.1 below.

---

**Box 1.1 Well-known feminist theories**

**Marxist feminism**

This feminist theory says capitalism is the cause of the unequal distribution of power between men and women. It focuses on women’s position within the family in capitalist societies and argues that although women play an important role in the production of capital, they are exploited both in the private domain of the home and family, and the **public domain/sphere** of paid work within the economy.

In terms of the private domain, Marxist feminism sees women as slaves within the family who provide what is called ‘free labour’ which reproduces the workforce that capitalism requires at no cost. The word ‘reproduce’ is used in two senses here. One is in terms of the way that women literally ‘reproduce’ because they produce children who will be future workers. The other relates to the Marxist feminist argument that women also ‘reproduce’ the workforce because the caring work they undertake within the family enables their children and their husbands to function effectively as workers under capitalism. This caring work is not only unpaid but unnoticed and undervalued. In the public sphere, women are exploited in several ways. For instance, they are overrepresented in caring occupations and the aforementioned undervaluing of caring work is reflected in the occupational structure of capitalist societies. They are also viewed as a **reserve army of labour** to be used in the economy to increase the labour supply when required and therefore reduce wages.

Thus, Marxist feminists conclude that within capitalism women are exploited as reproducers **and** producers. It is this emphasis on capitalism within Marxist feminism that has led to criticisms of its analyses for prioritizing capitalism over patriarchy and not attributing relevant significance to the latter (Barker 1997; Steel and Kidd 2001).

**Radical feminism**

Radical feminists emphasize that men, as opposed to the economic system, are the primary exploiters of women. For them, patriarchy is based on the fundamental biological differences
Chapter 1  Studying the social aspects of health

between men and women and hence women’s oppression by men is inherent in patriarchal societies. Patriarchy is ‘transhistorical’ and ‘transcultural’ in that whatever the historical period or culture, men systematically dominate and shape society to meet their needs rather than the needs of both males and females. Such domination is both physical and sexual (Firestone 1979). According to radical feminists, women can achieve freedom by wresting control of their bodies and fertility from men. They also argue that new technology can help eliminate some of the obstacles to achieving this freedom.

Criticisms of this feminist theory include its lack of recognition of the variations in the interpretation of biological differences between men and women across time and between cultures. For instance, during the First and Second World Wars, women’s biological inferiorities were overlooked in the need to fill gaps in the workforce created by the absence of men from traditional ‘masculine’ jobs (Oakley 1972, 1984). Another flaw in radical feminism that has been highlighted is that not all gender relationships are characterized by oppression and exploitation. Furthermore, despite all the changes in women’s position in society over the past 50 years, there is no evidence to suggest that a matriarchal society would be preferable.

**Liberal feminism**

In line with the thinking of liberalism – that individuals should be treated in accordance with their efforts as opposed to their birth or heredity – liberal feminists argue that men and women should have equal rights. Such gender equality should be achieved through the existing legal structures in society. Hence, rather than advocating a radical transformation of gender relationships, liberal feminists believe in campaigning to remove all social, political, economic and legal obstacles that prevent women having the same rights and opportunities as their male counterparts.

While many liberal feminists maintain that there have been moves to greater equality between the sexes as a result of campaigning, the extent to which this has occurred in both the public and private spheres is much debated. Critics of liberal feminism also point to the evidence that although the gender pay gap is decreasing, women are still primarily responsible for the day-to-day running of the home (Sullivan 2000; Abbott 2006; National Statistics 2007; Gatrell 2008).

The development of these different strands has led to feminism in general being accused of lacking internal coherence as a social theory. However, it has had substantial impacts both intellectually and as a social movement. It challenged earlier sociological theories because of the way they focused on a narrow range of topics and ignored gender. Indeed, feminism’s greatest contribution is probably its attack on the ‘malestream’ tradition of mainstream sociology which renders women invisible. Hence it not only forced an intellectual reconsideration of established thinking and theories but also stimulated research into gender issues nationally and internationally. As a social movement it has helped women to achieve greater economic, political, legal and social equality and still strives for improvements in women’s lives. In relation to the study of the social aspects of health specifically, it has drawn attention to many important, yet previously unrecognized, issues about women’s health. These include the social causes of women’s illness which were ignored because women were defined within medicine solely by their biology and reproductive capacity. By offering varying analyses, the broad tendencies within feminist theory enhance understanding and help to shape effective action aimed at addressing such issues (Barker 1997; Abbott et al. 2005).
**Activity 1.2**
The different types of feminism can be confusing when you first come across them. Read through them once again and complete the following table. This activity will help to consolidate your understanding. Some suggestions about what you could have included in each box can be found in the ‘Activity feedback’ chapter on page 223.

<table>
<thead>
<tr>
<th>FEMINIST THEORY</th>
<th>CAUSE(S) OF INEQUALITIES BETWEEN MEN AND WOMEN</th>
<th>SOLUTIONS</th>
<th>CRITICISMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marxist feminism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radical feminism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liberal feminism</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Functionalism**
In contrast to the preceding theories, functionalism focuses on those factors that bind society together to make it stable. This theory sees society as a biological organism (such as the body), made up of different integrated social structures which have to work together (as the different parts of the body do) in order for society to function properly and for social order to be maintained. These social structures comprise sub-systems and social institutions. Within these, individuals are allocated to social roles. Correct performance of social roles is essential for the maintenance of social stability. A central value system ensures that there are shared cultural and social expectations about the way each role should be carried out and the way others should respond. These social expectations are called role relationships, each of which carries with it a specific set of rights and obligations. For instance, in a classroom, a teacher has the right to control the class and is expected to teach the class effectively. The children in that classroom have a right to the education being provided and are expected to behave in a responsive manner. Social institutions themselves also have to perform specific functions that are necessary to maintain social order and for the continuation of social life. Using the family as an example, this social institution uses the process of socialization to ensure that the next generation continues to perform social roles.

Returning to the analogy of the body, according to functionalism, malfunction occurs when individuals within their sub-systems and social institutions solely pursue their own interests and do not adhere to the central value system in fulfilling their roles and relationships. Such malfunction can cause damage across the whole social system in the same way that disease does when it affects a part of the human body. Similarly, if the malfunction is not addressed, society cannot operate effectively and loses its order and solidarity (Parsons 1964; Jones 1994).

Functionalism presents an essentially ‘consensual’ representation of society; the consensus is based on an agreement to sustain society and shared norms and beliefs. When change occurs, a state
of equilibrium is restored through the establishment and acceptance of new consensual agreements. Some everyday activities can also have a latent consensual function in maintaining the system as a whole. For example, in addition to the nutritional function of food, this perspective would also point to the way it reinforces social groupings and cultural practices within a society (Lupton 1996).

Therefore, functionalism is viewed as a **consensus theory**. Such theories use organic analogies and argue that society survives and remains stable because of the broad acceptance by the majority of its citizens of consensual beliefs. They also assert that the natural state of society is one of dynamic equilibrium which copes with change by restoring balance and harmony. However, functionalism has been criticized for assuming that all those within the sub-systems do actually share the same understandings about situations to such an extent. In addition, criticisms have been levied at its prescribed and static notions about social roles and the way that individuals passively carry out those roles. Nonetheless, this perspective has made significant contributions to the understanding of key areas of the social aspects of health, such as the experience of illness and healthcare systems. One of the most influential theorists within functionalism is Parsons, and we will be referring to his work when these issues are discussed in Chapters 6 and 11 respectively.

**Symbolic interactionism**

As indicated above, functionalism is concerned with how individual motivations and actions are in alignment with the central value system of society rather than an individual’s own aims, beliefs and consciousness. Symbolic interactionism puts forward a different view of the role of the individual in social life. This theory is interested in people as active social actors; it focuses on how they make and define their own reality through their perceptions and interpretations of the social world that arise from their interactions with each other. Furthermore, social roles and norms are learned through these interactions. Indeed, symbolic interactionism developed as a reaction against perspectives such as functionalism which presented individuals as passively responding in a puppet-like way to the social system. Another point of distinction between functionalism and symbolic interactionism is the views they adopt about the nature of the social world. We have seen how functionalism makes use of analogies associated with the natural world, such as the human body. This means that it sees the social world as objective and observable. In contrast, symbolic interactionism sees the social world as being made up of its individual participants motivated by human consciousness. Consequently, symbolic interactionism argues that the meaning of human action is not observable but is subjective and has to be interpreted by studying the meanings that people attach to their behaviour.

Hence, this theoretical perspective focuses on **micro** elements of society which are the small-scale aspects of human behaviour such as the face-to-face interactions between individuals and between individuals and groups. Research adopting a symbolic interactionist approach begins with the individual and focuses on explaining the social world from the point of view of the subjective individual as a social actor. Criticisms of symbolic interactionism have centred around the way it ignores structural factors, does not place individuals and groups within a wider social context and offers depth at the expense of breadth. Despite these criticisms, this perspective has generated invaluable understandings of meanings and their fluidity. It has also produced many insights into the social aspects of health, and work carried out within a symbolic interactionist theoretical framework will be referred to in Section 2 of this book when discussing experiences of health and illness (Hochschild 1983; Cuff et al. 2006).

**Postmodernism**

The term postmodernism itself is broad and is used in a range of academic disciplines when describing the profound social changes that occurred at the end of the twentieth century in what
sociologists refer to as the move from industrial to post-industrial society. These changes not only include the transformation of industrial organization but also of class structure, religious allegiances and political life. As a result, contemporary life is less certain, identities are more fluid and society has become more diverse, pluralistic and fragmented. Stuart Hall, a leading sociologist, summarized this phenomenon in the following quotation from an article written in the 1980s:

Our world is being remade. Mass production, the mass consumer, the big city, big brother state, the sprawling housing estate, and the nation state are in decline: flexibility, diversity, differentiation, and mobility, communication, decentralization and internationalization are in the ascendant. In the process our own identities, our sense of self, our own subjectivities are being transformed. We are in transition to a new era.

(Hall 1988: 24)

As this book will demonstrate, many existing sociological theories, such as Marxism and functionalism, have become unsustainable in their original form and have required adaptation because they are historically and culturally relative. Postmodernism is the most recent sociological theory and challenges the all-embracing nature and expressions of certainty about the social world of its theoretical predecessors. It searchs for new ways of explaining our changed social world with its decline in absolutes and the collapse of meaning. In doing so, it emphasizes that we can never uncover the truth, be objective or have a theory about the social world. This is because social life is continually constructed and reconstructed through our everyday interpretations and actions, and therefore knowledge about the social world is constantly changing. Indeed, postmodernism argues that we are ‘agents’ who can make an increasing number of choices about how we shape our lives and identity, rather than having our behaviour and roles prescribed by the society in which we live. This focus on human subjects and human action has also led sociologists to direct their attentions to agency as opposed to structure.

Postmodernism has several strands. One of these is social constructionism, which refers to how social reality is actively viewed or ‘constructed’ in a particular way by individuals and groups as a result of social relations and human agency rather than being ‘natural’ or biological in origin. Social constructions of different aspects of society or behaviour vary historically, socially and culturally. Thus, there is no obdurate reality because we make our own and social reality is essentially contestable (Giddens 1992; Cuff et al. 2006).

Postmodernism has been accused of not being a unified theory and overemphasizing choice in its conceptualization of human beings as ‘agents’. Nonetheless, this theory has been credited with extending the boundaries of sociological enquiry and challenging analyses proffered across a range of theoretical bases. Using feminism as an example, postmodernism has questioned whether patriarchy is so pervasive throughout society and in women’s lives, and consequently has raised awareness of the variations in the experiences of womanhood. It has also contributed to the study of the social aspects of health. An example is the way it shows how medical knowledge is a product of those engaged in its practice in particular societies and historical periods. This has in turn highlighted the fluid and dynamic nature of medicine and the extent to which it lacks neutrality. Therefore, postmodernism has challenged the ‘truth’ of medical knowledge, and we will draw on this work throughout the book. Furthermore, many of the societal changes it refers to have been used in the exploration of new areas in the study of health. For instance, the growth in individualization and reflexivity that postmodernists assert are features of post-industrial society has been used in relation to lifestyles and risks to health (Giddens 1992).
### Activity 1.3

The following concepts are all referred to in the discussions of the theoretical perspectives above. Using the table below, place them under the correct perspective. When you have finished, compare them with the list of key concepts within each perspective that are set out in the answer to this activity in the ‘Activity feedback’ chapter on page 224.

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Marxist theory</th>
<th>Feminism</th>
<th>Functionalism</th>
<th>Symbolic interactionism</th>
<th>Postmodernism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active social actors</td>
<td>Economy of a society</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency</td>
<td>Education system</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alienation</td>
<td>Equality of the sexes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analysis should begin with the individual</td>
<td>Equilibrium</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bourgeoisie</td>
<td>Exploitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitalism</td>
<td>Human consciousness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central value system</td>
<td>Impossibility of uncovering the truth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consensual representation of society</td>
<td>Individuals make their own reality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural and social expectations</td>
<td>Knowledge about the social world is constantly changing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women's subordination to men is 'natural'</td>
<td>Society is like a biological organism</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proletariat</td>
<td>Lack of objectivity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Means of production</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oppression and exclusion of women</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patriarchy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-industrial society</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social construction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social order</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social roles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Socialization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Understand and interpret human action</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sub-systems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Focus on the individual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>rather than society</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Health data
An important issue in the study of the social aspects of health is the use of data about variations in health in our society. Differences in health between various groups in society are usually measured in terms of morbidity and mortality rates. The former refer to the numbers and patterns of physical and mental illnesses within a designated group at a given time, while the latter refer to numbers and causes of deaths within a designated group at a given time. Both are expressed as a rate per 100,000 of the population and reductions in either or both are equated with improved health. Mortality rates are also used to calculate the most widely used indicator of population health in general – life expectancy at birth. This provides an estimate of the average number of years a newborn baby can expect to live if patterns of mortality at the time of their birth were to stay the same throughout their life.

The measurement of health is controversial. One area of controversy has been the indicators used, which have been accused of lacking objectivity. Taking morbidity rates first, these are compiled using self-reported health, and yet such self-reports have been found to consistently underestimate disease which is clinically identified and people inevitably define their health in different ways. Service utilization rates (such as visits to GPs and number of inpatient hospital stays) have also been used as indicators of morbidity but these can be inaccurate because the extent of a patient’s use of health services can be influenced by a variety of individual and social factors. These factors include changes in policies on service provision and length of utilization – for instance, policy initiatives over the past two decades have resulted in considerable increases in day surgery and reductions in the length of inpatient hospital stays.

With reference to mortality rates, a key indicator used is occupation. As we shall see in Chapter 3, the way occupations are classified is regularly revised and also varies between studies. Therefore, comparisons of findings can be questionable. Furthermore, important information has been omitted because married women have typically been classified according to their husband’s occupation (Bowling 2005; Steel et al. 2008; Graham 2009). More generally, concern has been expressed about the way that the social processes involved in measuring health introduce varying degrees of bias and subjectivity.

Hence, refinements to the methods and models used for measuring health differences are continually being made. Although it is important to be aware of the problems associated with measuring morbidity and mortality rates, it is equally important to realize the full potential of such data in increasing knowledge about the social aspects of health. The patterns that emerge from careful analyses of morbidity and mortality data have been invaluable in showing how health and illness are produced by social relationships and inequalities, as opposed to random biological events. These insights are often further enhanced by the use of data from other indicators, such as smoking rates, obesity levels and data about specific illnesses. Therefore, in order to develop your understanding of the social aspects of health as much as possible, morbidity and mortality figures will feature in several chapters of this book, and, where necessary, they will be used in conjunction with other health indicators.

Influences on health
During the course of the discussions in this book, reference will also be made to many of the influences on health. Those that are most frequently discussed in the study of the social aspects of health, plus a summary of their specific impacts on health, are set out below. The reader will be referred back to this list as appropriate.
Chapter 1  Studying the social aspects of health

- **Smoking**: more deaths can be attributed to smoking than to any other single risk factor. It causes a third of all cancers: lung cancer, cancer of the mouth, larynx, oesophagus, bladder, kidney, stomach and pancreas. Other smoking-related causes of death are chronic obstructive lung disease (including bronchitis), heart disease, asthma and brittle bone disease (osteoporosis) (Department of Health 1998; Office for National Statistics 2006b, 2009).

- **Drinking**: consuming alcohol above the recommended guidelines leads to health problems both immediately and in later life. These problems include cirrhosis of the liver, heart disease, strokes and some cancers (Busfield 2000a; Office for National Statistics 2006a, 2009).

- **Exercise**: the beneficial effects of physical exercise are extensive and include the way it promotes mental well-being and musculoskeletal health. Lack of physical exercise contributes to many chronic diseases such as cardiovascular diseases, strokes, Type 2 diabetes, osteoporosis and some cancers (Department of Health 2004a; Graham 2009).

- **Weight**: being overweight, and particularly being obese, is linked to many health problems which range from poorer self-rated health and infertility to much more significant illnesses such as diabetes, cardiovascular disease, certain cancers, hypertension, respiratory problems and musculoskeletal diseases. It can also contribute to premature death (Simonsen et al. 2008; Weaver et al. 2008; Marmot 2009).

- **Substance misuse**: in addition to leading to death, substance misuse has many negative effects on health. These include anxiety, memory and cognitive loss, psychiatric disorder, HIV infection, accidental injury, hepatitis and coma. It may also result in an increased risk of sexually transmitted diseases (National Institute for Health and Clinical Excellence 2007; Bradby 2009).

- **Poor housing**: this often goes hand-in-hand with overcrowding, lack of central heating, and damp, rot, mould, lack of light and a poor state of decoration. Such living conditions can adversely affect mental and physical health. Examples of mental health problems identified are anxiety and depression. Physical health problems include increased vulnerability to respiratory illnesses (such as asthma) and enteric diseases (such as vomiting and diarrhoea) (Wilkinson 1999; Krieger 2002).

- **Deprived neighbourhoods**: living in a deprived area inevitably involves experiencing many disadvantages, for instance, higher crime rates, lack of amenities and low employment opportunities. These have been linked to higher anxiety and depression rates. Furthermore, such areas are less conducive to a healthy lifestyle – residents have higher smoking rates and lower rates of exercise (Wilkinson 1999).

**Conclusions**

This chapter has provided you with comprehensive explanations of issues that are central to the study of the social aspects of health in this book. Having developed your knowledge of these issues, you are now in a position to begin to explore the chapters in the rest of the book. Readers are advised to return to this chapter should they wish to refresh their understanding of any of the points discussed when they are referred to in later chapters. Enjoy and good luck!
Chapter 1  Studying the social aspects of health

**Key points**

- Several disciplines inform the study of the social aspects of health, however it is the sociology of health and illness and the sociology of the body which are most frequently drawn upon.

- Many theoretical perspectives about our social world have both informed, and continue to inform, the study of the social aspects of health.

- Although health measurement is problematic, data on health is essential to the study of the social aspect of health.

- The most frequently discussed influences on health within the study of the social aspects of health are smoking, drinking, exercise, weight, substance misuse, poor housing and deprived neighbourhoods.

**Discussion points**

- What do you think having a ‘sociological imagination’ requires?

- What are the main differences between conflict and consensus theories?

- In what ways do you think sociology can enhance the study of the social aspects of health, illness and healthcare?

**Suggestions for further study**

- Chapter 4 in Naidoo and Wills (2008) provides a good overview of the contribution of sociology to the study of health as well as addressing some of the central concerns and debates in the sociology of health.

- If you wish to explore the latter in more depth, Earle and Letherby’s (2008) highly readable book, *The Sociology of Healthcare* comprises a collection of readings which cover a range of issues within the sociology of health and illness. While these encourage the reader to think sociologically, they do not assume prior knowledge of sociology.

- A quick look at the indexes to the journals *Sociology of Health and Illness* and *Social Science and Medicine* will give you a greater insight into the range of issues included in this subject area and furnish you with ideas for future sources of material.

- Should you wish to explore the theoretical perspectives in more detail, see Cuff *et al.* (2006). Chapter 1 in Barry and Yuill (2008) will also be useful.